GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF THE INSPECTOR GENERAL

D.C. OFFICE OF THE CHIEF MEDICAL EXAMINER

INCIDENT REPORT ON THE DEATH OF DEBORAH WILSON

CHARLES C. MADDOX, ESQ.
INSPECTOR GENERAL

This Redacted Incident Report describes the Office of the Inspector General's (OIG) evaluation of the Office of the Chief Medical Examiner's pronouncement of death for Deborah Wilson. The OIG is providing this redacted report in lieu of the full Incident Report to preserve the privacy interests of individuals referenced in the full report.

OIG No. 03-0008OCME

APRIL 2003

Inspections and Evaluations Division

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The Inspections and Evaluations (I&E) Division of the Office of the Inspector General is dedicated to providing District of Columbia (D.C.) Government decision makers with objective, thorough, and timely evaluations and recommendations that will assist them in achieving efficiency, effectiveness and economy in operations and programs. I&E goals are to help ensure compliance with applicable laws, regulations, and policies; to identify accountability; recognize excellence; and promote continuous improvement in the delivery of services to D.C. residents and others who have a vested interest in the success of the city.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

April 9, 2003

Jonathan L. Arden, M.D.
Chief Medical Examiner
Office of the Chief Medical Examiner
1910 Massachusetts Avenue, Southeast
Washington, D.C. 20004

Dear Dr. Arden:

Enclosed is our final *Incident Report on the Death of Deborah Wilson*. The Report reflects your agency's comments, as appropriate, and we note concurrence with our findings.

If you have questions, please contact me or Alvin Wright, Jr., Assistant Inspector General for Inspections and Evaluations at 202-727-9249.

Sincerely,

Charles C. Maddox, Esq.
Inspector General

Enclosure

CCM/AW/jcs

cc: Ms. Margret Kellems, Deputy Mayor, Public Safety and Justice
Arabella W. Teal, Interim Corporation Counsel, Office of the Corporation Counsel

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ACRONYMS:

DOA:	Dead On Arrival
FEMS:	Fire and Emergency Medical Services
MLI:	OCME Medicolegal Investigators
MPD:	Metropolitan Police Department
PDOA:	Presumed Dead On Arrival
OCME:	Office of the Chief Medical Examiner
OIG:	Office of the Inspector General
VCU:	Violent Crimes Unit

DEFINITIONS:

Apneic:	Without respiration.
Asystole:	Absence of electrical activity.
Lividity:	Discoloration due to the settling of blood by gravity after death.
Rigor Mortis:	Stiffness of muscles occurring after death.

INCIDENT REPORT
ON THE DEATH OF DEBORAH WILSON

Background

On Thursday, November 21, 2002, *The Washington Post* (*Post*) reported that:

> **[a] District woman believed to be dead was placed in a body bag by a team from the D.C. medical examiner's office, taken to the morgue and put in a refrigerated box until an investigator – who was called to officially declare her dead – found a pulse.**

According to the *Post* report, on November 15 Deborah Wilson was found in her bedroom "apparently suffering from cardiac arrest." Paramedics from the District's Fire and Emergency Medical Services (FEMS) arrived and performed steps to check for vital signs. Then, believing Wilson to be dead, the paramedics contacted the Office of the Chief Medical Examiner (OCME). OCME sent two employees to retrieve the body, and when it was moved, one of the employees was quoted as saying that he heard Wilson sigh and moan. His colleague was quoted as saying "It's just aspirations. No big deal." The *Post* article quoted a "source" as saying: "It bothers me because the woman may have been alive when we put her in the damn plastic bag. I don't want to feel like I had a part in her death."

As reported by the *Post*, OCME employees and the OCME Investigative Report stated that, after Wilson's body arrived in the OCME mortuary, a mortuary technician checked her in. Wilson's height and weight were taken; she was also photographed, tagged and placed in the cooler. Physician's Assistant [redacted] examined the body and thought she felt a pulse. She summoned the medical examiner on duty, [redacted]. [redacted] also thought she felt a pulse. [redacted] instructed the mortuary supervisor to call 911, and [redacted] and [redacted] began administering rescue breathing using a portable air bag to pump air into the lungs. FEMS paramedics arrived in response to the 911 call and connected Wilson to a cardiac monitor, but found no signs of life.

In an interview with the *Post*, Chief Medical Examiner Jonathan Arden, M.D., reportedly stated that he did not have a good explanation for staff members saying they felt a pulse. Nevertheless, the *Post* quotes Arden as stating that he did not believe there was a pulse, and that there was "strong evidence" that Wilson was dead when the paramedics were called to the morgue.

Issue of Concern and OIG Action

The *Post* and other media reports generated speculation as to whether Wilson could have been alive when she was placed into the cooler at OCME. Specifically, reports quoted sources who indicated that Wilson might have been alive in her apartment and that OCME employees felt a pulse.

At the time the above events transpired, an Inspection Team (Team) from the Office of the Inspector General (OIG) was on site at OCME conducting a routine and previously scheduled inspection of OCME operations (see Attachment 1). A report on this inspection will be issued within the next few months. Consequently, the Inspector General directed the Team to continue its inspection, but to give priority attention to an evaluation of this incident in order to address promptly any concerns in regard to the handling of Wilson's death. The team interviewed FEMS, Metropolitan Police Department (MPD), and OCME employees and reviewed documents pertinent to this particular case.

Perspective

In general, OCME investigates all deaths in the District of Columbia that occur as the result of violence; those that occur unexpectedly, under suspicious circumstances or while a person is in custody; and those that are related to a disease that may pose a threat to public health. *See* D.C. Code § 5-1405 (b) (LEXIS through July 26, 2002).

OCME is charged with determining "with reasonable medical certainty the cause and the circumstances surrounding each death required to be investigated," and must complete a report explaining the medical examination of the decedent. *See* 22 DCMR § 2401 (b); D.C. Code § 5-1409 (a) (LEXIS through July 26, 2002).

Finally, the Chief Medical Examiner is required to perform (or ensure that another qualified pathologist performs) an autopsy where additional investigation regarding the cause or manner of death is warranted. *See* D.C. Code § 5-1409 (b) (LEXIS through July 26, 2002).

Summary of Findings

Was Wilson deceased before being examined by OCME employees?

Discovery of the Body. Two maintenance men who entered Wilson's apartment with the permission of the building's property manager to check her electrical box discovered her body and contacted the property manager, [redacted]. The OCME investigative report shows that [redacted] entered the apartment and felt for a pulse but did not find one. [redacted] then dialed 911.

Paramedic Examination at Wilson's Apartment. FEMS dispatched paramedics to Wilson's apartment at 10:57 a.m. The first FEMS employee to arrive, however, was [redacted]. [redacted] is a FEMS quality assurance supervisor who evaluates other paramedics and is also a certified and experienced paramedic. [redacted] stated that he arrived with advanced life support equipment, including oxygen, and when he examined Wilson, he found her body pulseless and apneic. He also stated that her skin was cold, her pupils were fixed and dilated, and she was in rigor mortis with dependent lividity. [redacted] attached three leads from a cardiac monitor to Wilson's body in order to detect any heart function. All three leads showed asystole. [redacted] concluded that Wilson met FEMS established protocols for a conclusion of "Presumed Dead On Arrival" (PDOA) (Attachment 2). The two paramedics who were dispatched to the scene observed the condition of Wilson's body and [redacted] examination and, based on the extent of Wilson's rigor mortis, questioned [redacted] use of the cardiac monitor since Wilson was clearly PDOA. [redacted] stated that it is his practice to take the extra step to ensure accuracy. The two paramedics agreed with his conclusion of PDOA. He completed the necessary FEMS follow-up reports to document the event (Attachment 3).

Other Witnesses at the Scene. MPD Officer [redacted] was dispatched to the scene as the result of a 911 call for a person found unconscious. [redacted] stated that he arrived at the scene just as the paramedics were coming out of the building and that the paramedics told him they had a Dead On Arrival (DOA). Pursuant to D.C. Code § 5-1406 (b) (2001),[1] he contacted OCME at approximately 11:42 a.m. to report Wilson's death. He stated that Wilson's sister and brother-in-law, and two detectives from the MPD Violent Crimes Unit (VCU) came to the apartment prior to the arrival of OCME personnel. Detective [redacted] of VCU stated that he examined Wilson's apartment and determined that there had been no forced entry into the apartment. He also stated that he briefly observed Wilson and concluded that there were no signs of life. Officer [redacted] stated that after the OCME mortuary staff arrived at 1:03 p.m.[2] to pick up Wilson's body, he noticed that her body fluids had been released onto the carpet. He stated that when body fluids are released, "you're dead." OCME left the apartment with Wilson's body at 1:30 p.m. [redacted] followed-up with a report on the incident, per MPD procedures (Attachment 4).

[1] This statute requires law enforcement and EMS personnel (among others) to notify OCME promptly of any deaths under OCME's jurisdiction (e.g., suspicious or unexplained deaths).
[2] OCME had two other scheduled pick-ups prior to retrieving Wilson.

OCME Personnel. An OCME Intake employee took Officer [redacted] call reporting Wilson's death at 11:42 a.m. Given the shortage of staff and the higher priority assigned to other cases in progress, the OCME investigator on duty, [redacted], decided to send technicians from the Mortuary Unit to pick up the body and bring it back to OCME for examination and official pronouncement of death. She informed [redacted], her supervisor, of her decision and he agreed. According to Dr. Arden, the general rule is that Medicolegal Investigators (MLI) will go to the scene of a death if possible. However, because of insufficient OCME staff, Dr. Arden stated that it is not uncommon to retrieve a body, as was done in Wilson's case, and deliver it to OCME for an examination and pronouncement of death where there is no evidence of a homicide or foul play. Wilson's body arrived at OCME at 1:45 p.m. and was checked-in.

[redacted] stated that at approximately 2:45 p.m., she went to the OCME mortuary to pronounce Wilson dead after Officer [redacted] called and requested this information for his report. She stated that while checking for a carotid pulse, she thought there may have been a slight pulse even though the decedent's upper extremities were stiff. She stated that she also checked for rigor mortis and found Wilson "stiff and cold." [redacted], one of the mortuary technicians on duty, told [redacted] that Wilson had been in the cooler approximately 10 minutes. [redacted] stated that she summoned [redacted], the medical examiner on duty. [redacted] said she also felt a pulse. She attempted rescue breathing but there was no response. They called 911, and FEMS paramedics arrived within 5-10 minutes. The paramedics attached a cardiac monitor to Wilson, and found Wilson to be "Asystole pulseless" (Attachment 5, *Supplemental Report*). Wilson was officially pronounced dead at 3:00 p.m.

[redacted] confirmed that after being summoned by [redacted], she also thought she felt a pulse. Following the unsuccessful rescue breathing attempts, however, [redacted] checked again for a pulse. She stated that on the second attempt, she did not feel one. [redacted] stated that Dr. Arden joined them at about the same time that FEMS arrived and while she and [redacted] were still checking Wilson's body. [redacted] stated that Arden asked why they checked for a pulse when there were signs of rigor mortis. [redacted] stated that Arden had previously issued instructions to check for a pulse in all cases.

Chief Medical Examiner. Dr. Arden reviewed all of the events concerning Wilson's death and concluded, unequivocally, that Wilson was deceased when found in her apartment, notwithstanding [redacted] and [redacted] perceptions of a pulse in Wilson's body at OCME. He stated that he believes that the staff members in this case are competent individuals who made a mistake in checking for a pulse in the first place because the decedent was in rigor mortis; more than likely, according to Arden, these individuals felt their own pulse instead of that of Wilson. The *Post* quoted Arden as saying that there was the perception that the staff members felt a pulse, but what they were feeling was likely their own pulse in their fingers. Arden summarized his official finding in a letter to the editor of the *Washington Post* (Attachment 6).

Conclusion: Based on the actions taken and reported by the attending paramedics at both Wilson's apartment and OCME, statements by MPD Officer [redacted], and a review of FEMS and MPD official written reports regarding Wilson's death, the preponderance of the evidence indicates that Wilson was dead when she was examined in her apartment and, therefore, dead

when she was examined at OCME. In addition, a preponderance of the evidence indicates that the actions taken and procedures followed by FEMS and MPD personnel were appropriate in these circumstances.

ATTACHMENTS

Attachment 1:
1. Letter of Intent to Inspect the Office of the Chief Medical Examiner.
2. Terms of Reference.

Attachment 2: Protocol for a Conclusion of Presumed Dead On Arrival (PDOA) Status.

Attachment 3: FEMS Incident Report.

Attachment 4: Metropolitan Police Department *Incident-Based Event Report*.

Attachment 5: *Supplemental Report* by [redacted].

Attachment 6: Jonathan L. Arden, M.D. Letter to the Editor of *The Washington Post*, 26 November 2002.